CADAP

State of Connecticut
Department of Social Services

The Connecticut AIDS Drug Assistance Program

WHAT IS CADAP?

The Connecticut AIDS Drug Assistance Program (CADAP) is a pharmaceutical assistance program that pays for HIV/AIDS medications approved by the U.S. Food and Drug Administration (FDA) and other drugs that may prevent the serious deterioration of the health of persons who have Human Immune-deficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS). The Department of Social Services administers this program.

COVERAGE

CADAP only pays for drugs covered under its formulary. If your application is approved, you will receive a program eligibility card. Take this card to your pharmacist. Your pharmacist will bill the State directly for drugs covered under CADAP (minus any other insurance coverage you may have). A complete listing of drugs covered under CADAP is sent with the CADAP approval letter. Because continued funding is uncertain, the scope of services and conditions of participation in CADAP may change in the future.

WHO IS ELIGIBLE?

To qualify, the eligibility criteria are:

- Be a Connecticut resident.
- Be diagnosed by a licensed physician as having at least one of the following medical conditions:
  - Acquired Immunodeficiency Syndrome (AIDS),
  - Human Immunodeficiency Virus (HIV) positive symptomatic, or
  - HIV infection.
- The total income limit of an individual or the individual's family must be equal to or below 400% of the Federal Poverty Level. **There is no asset limit.**

For income eligibility, your **net monthly income** is needed. Net monthly income is your **gross earned income** received in a calendar month minus any required deductions (such as taxes or deduction for health insurance premiums) and your **unearned income**, which is the amount from any benefit received, such as SSI or SSDI.

As a condition of eligibility for CADAP, you must also apply for State Medical Assistance, Medicaid (Title XIX). Completion of this application will automatically initiate the Medicaid application process unless you already have a pending Medicaid application at the Department's Regional Office. **If you are within the income and asset limits for Medicaid eligibility, you will be required to complete another form with more detailed information.**

MEDICAL INSURANCE

You can be eligible for CADAP and also have a medical insurance plan with or without prescription drug benefits. If you have an insurance plan with prescription drug coverage, please attach a copy of your medical insurance card (front and back) along with the application. **If your insurance policy is terminated or changed, please notify and send the policy termination letter to the CADAP Office immediately.**

You are not eligible for CADAP if you now have medical coverage through:

- Medicaid (**Title XIX**),
- State Administered General Assistance Program (**SAGA**),
- Connecticut Pharmaceutical Assistance Contract to the Elderly and the Disabled (**ConnPACE**),
- The Department of Veterans' Affairs (**VA**), or
- Town Administered General Assistance Program (**GA**).

To be eligible for VA medical care, a veteran must have served at least 180 days active duty and have an honorable or general discharge.

HOW TO APPLY?

Please complete Section I, II, III, and IV of the attached application form. Your physician must complete Part V. Mail the application to the CADAP mailing address at:

Department of Social Services
Medical Operations Unit #4
25 Sigourney Street
Hartford, CT 06106-5033.

ELIGIBILITY RENEWAL

Eligibility for CADAP is reviewed at one (1)-year intervals.

Approximately sixty (60) days prior to the expiration of your eligibility, the Department will mail a renewal application to you. Complete and sign the renewal application and return to the CADAP mailing address by the due date on the notice.

SHOULD I NOTIFY CADAP OFFICE OF ANY CHANGES BEFORE MY ELIGIBILITY EXPIRES?

Please notify the CADAP office when any of the following changes occur:

- Your address or name is changed,
- Your medical insurance policy is changed or terminated, and/or
- Your contact person or authorized representative is changed.

FOR MORE INFORMATION CALL THE CADAP PROGRAM TOLL-FREE NUMBER: 1-800-233-2503

You may obtain an updated CADAP formulary and application by calling the program Toll-Free number or go to the Department's web-site at: www.dss.state.ct.us.

Services are available without regard to race, color, creed, sex, age, disability, national origin, ancestry or language barriers. Deaf and hearing-impaired individuals may use a ***TDD/TTY*** by calling **1-800-842-4524**. Questions, concerns, complaints or requests for information in alternative formats must be directed to the Public and Government Relations Office at **1-800-842-1508**.

APPLICATION FOR CONNECTICUT
AIDS DRUG ASSISTANCE PROGRAM
AND
MEDICAID PROGRAM

Please complete Sections I, II, III, IV and have your doctor complete Section V. Your application is treated confidentially.

☐ Yes I wish to receive CADAP notices and forms in Spanish Only.

SECTION I -- APPLICANT AND HOUSEHOLD INFORMATION

1. Name

_____
First Middle Initial Last

2. Are you currently eligible for any of the following programs administered by the Department of Social Services?

Medicaid, HUSKY A, SAGA/GA ☐ Yes ☐ No If yes, your Client ID No.:_____

ConnPACE ☐ Yes ☐ No If yes, your Client ID No.:_____

If you are eligible for any of the above programs, you are not eligible for CADAP.

3. Residential Address

_____
Street Address Box or Apt. #

_____
City State Zip Code

4. Mailing Address *(if different)*

_____
Street Address Box or Apt. #

_____
City State Zip Code

5. Telephone No.: (_____) _____ — _____
Area Code

6. Date of Birth _____/_____/_____
Month Day Year

7. Sex ☐ Male ☐ Female

8. Race

☐ Caucasian (Non-Hispanic) ☐ Asian ☐ Pacific Islander
☐ Black (Non-Hispanic) ☐ Native American ☐ Alaska Native/Eskimo
☐ Hispanic

9. Social Security Number:_____ — _____ — _____

(If you have not been assigned a Social Security Number, write in the letters N/A for not applicable.)

10. Contact Person, *if you cannot be reached* ***(optional)***

_____
Name: *First M.I. Last*

_____
Street Address Box or Apt. #

_____
City State Zip Code

Telephone No.: (_____) _____ — _____
Area Code

11. Authorized Representative, **e.g. Conservator, Guardian, Power of Attorney, etc**. *(This person shall receive notices sent by the Department including renewal notices.)*

_____
Name: *First M.I. Last*

_____
Street Address Box or Apt. #

_____
City State Zip Code

Telephone No.: (_____) _____ — _____
Area Code

MEMBERS OF HOUSEHOLD

Financial eligibility is determined by your family size and your family's net monthly income. Your family includes the following relatives who live with you: ***your spouse, your children under 18, and your parents if you are under 18.***

1. Full Name_____
   Date of Birth_____
   Sex ☐ M ☐ F
   Relationship to Applicant_____

2. Full Name_____
   Date of Birth_____
   Sex ☐ M ☐ F
   Relationship to Applicant_____

3. Full Name_____
   Date of Birth_____
   Sex ☐ M ☐ F
   Relationship to Applicant_____

4. Full Name_____
   Date of Birth_____
   Sex ☐ M ☐ F
   Relationship to Applicant_____

5. Full Name_____
   Date of Birth_____
   Sex ☐ M ☐ F
   Relationship to Applicant_____

6. Full Name_____
   Date of Birth_____
   Sex ☐ M ☐ F
   Relationship to Applicant_____

SECTION II -- FINANCIAL INFORMATION

FOR CADAP

For CADAP your net monthly income is needed. Net monthly income is your gross earned income received in a calendar month minus any required deductions (such as taxes or deduction for health insurance premiums) and your unearned income, which is the amount from any benefit received, such as SSI or Social Security.

The total net income received per month by all members of my family is: $_____

FOR MEDICAID

A preliminary determination of your Medicaid eligibility will be made on the basis of the following information. Verification of your income will be required as part of your Medicaid application.

Do you receive Social Security or SSI benefits based on disability? ☐ Yes ☐ No

Indicate your family's:

Gross Monthly Earned Income: **$**_____

Gross Monthly Unearned Income: **$**_____

Cash, money in the bank or other liquid assets for yourself or any household member: **$**_____

WHAT OTHER HELP DO YOU NEED?

☐ Money Assistance ☐ Help with Child Care ☐ Food Stamp Assistance
☐ Other *(Specify)*:_____

SECTION III -- MEDICAL COVERAGE INFORMATION

1. **Private Health Insurance Coverage**

Are you enrolled in a private insurance plan that pays for prescriptions? ☐ Yes ☐ No

If yes, provide the information below.

Insurance Company Name_____

Insurance Company Address_____

Policy Number_____ Group Number_____

Policy Effective Dates: Start_____ Stop_____

If different, Policy Holder Name_____

Relationship to Client_____

Please attach a copy of your medical insurance card (front and back) with this application. If your insurance policy is terminated, please notify the CADAP Office immediately and submit the policy termination letter to the CADAP Office as soon as possible.

2. **Medicare Benefits**

Do you receive Medicare Benefits? ☐ Yes ☐ No

If yes, what is your Medicare Claim No._____

Please attach a copy of your Medicare card (front and back) with this application.

3. **Health Care Benefits from the Department of Veteran Affairs (VA)**

Are you a veteran? ☐ Yes ☐ No

If yes, are you currently receiving VA medical benefits? ☐ Yes ☐ No

If no, did you ever serve on active duty for more than 180 days with the Air Force, Army, Coast Guard, Marines, Navy (regular or reserves), or National Guard? ☐ Yes ☐ No

If yes, was your discharge

☐ Honorable ☐ General ☐ Dishonorable ☐ Bad Conduct
☐ Undesirable

Did you first enlist after September 7, 1980? ☐ Yes ☐ No

How long did you serve on active duty? ☐ Over 2 years ☐ Less than 2 years

☐ I am a veteran, but do not qualify for VA medical benefits. **My benefit denial letter from VA is attached.**

RELEASE

I hereby authorize the Department of Social Services (Department) to use and disclose records in its possession ***that have confidential HIV-related information, as specified in the Connecticut General Statues Section 19a-585,*** *indicating that _____, a Connecticut AIDS Drug Assistance Program (CADAP)*
(Print Applicant's/Client's Name)
applicant or client, has human immunodeficiency virus (HIV) infection, HIV-related illness or acquired immune deficiency syndrome (AIDS) to Department employees and agents, CADAP/Medicaid pharmacies, health insurers, medical or social services providers and auditors, for purposes associated with the administration of CADAP and the other programs administered by the Department.

This authorization is valid for the duration of any functions related to the operation of CADAP and the other Department programs.

Date Signed _____ Signature of CADAP applicant or client _____

or

Date Signed _____ Signature of legal guardian of the CADAP applicant or client _____

or

Date Signed _____ Signature of person authorized to consent to health care for the CADAP applicant or client _____

SECTION IV -- SIGNATURE

- I understand this application and affirm that the answers given are true to the best of my knowledge.
- I understand that the information on this application is subject to verification by the State. I may be subject to penalties for false statement as specified in the Connecticut General Statutes Section 53a-157b and 17b-97 and to penalties for larceny as specified in Section 53a-122, 53a-123 and 53a-124. I also may be subject to penalties for perjury under Federal Law.
- I understand that by receiving medical assistance, I allow the State to recover the cost of my medical bills, which may have been covered by other insurance directly from the insurance company.

Signature of Applicant or Client _____ Date _____

Signature of Authorized Representative _____ Date _____

SECTION V -- MEDICAL INFORMATION

This section must be fully completed by the applicant's physician.

I certify that I have prescribed drug(s) to treat HIV disease or prevent serious deterioration of health arising from HIV disease, including measures for the prevention and treatment of opportunistic infections for

_____
(name of patient)

who is/has:

☐ HIV Infection only ☐ HIV Positive Symptomatic ☐ CDC Defined AIDS

_____ _____
Physician's Signature Date

_____
Address

_____ _____
Physician's Printed Name Physician's License Number

Please mail the completed and signed application to: Department of Social Services, 25 Sigourney Street, Hartford, CT 06106-5033, Attn: Medical Operations Unit #4, Telephone Number: 1-800-233-2503

CADAP STAFF

Initial Application_____ Reapplication_____

Client ID No._____ Region_____

Medicaid/SAGA/GA	**AU NO.**	**DATE**
Name Not Found on Elig. File		
Granted Medicaid		
Granted SAGA		
Granted GA		
Spenddown ☐ Active Med.		
☐ Not Active Med.		
Pending		
Denied		
Closed		
Other Department Programs		

CADAP Eligibility Determination

☐ Eligible - Effective Date:_____
☐ Not Eligible

Worker Name:_____ Date:_____

Explanation:_____

REGIONAL OFFICE STAFF

Date Received:_____ Region:_____

Worker Name:_____ Worker ID:_____

Medicaid/SAGA Eligibility

When a determination is made notify the Central Office CADAP unit by completing the section below and returning a copy of this application form to the C.O. CADAP Unit.

If you have any questions please contact the C.O. CADAP Unit at 1-800-233-2503.

	Medicaid	**SAGA**		
Granted	☐	☐	Effective Date:_____	
Denied	☐	☐	Date:_____	Reason Code_____
			Effective Date:_____	
Spenddown Not Active Medicaid	☐	☐	Effective Date:_____	

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